

**APPLICATION FOR LICENSE TO OPERATE A HOSPITAL**

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH FACILITIES
SFN 8001 (7-05)

DEPARTMENT USE ONLY

License Number

Bed Capacity

Licensure Period

Telephone 701.328.2352

INSTRUCTIONS: Type or print clearly. Attach with the application a check or money order and other information as requested. Include the completed request for waiver, if applicable. Return one completed, notarized copy to: ND Department of Health, Division of Accounting, 600 East Boulevard Ave. Dept. 301, Bismarck, ND 58505-0200. Keep a copy for your records.

Official Name of Hospital			
Street Address	City	State	Zip Code
Business Address	City	State	Zip Code
County	Business Telephone Number	Fax Number	
E-Mail Contact	E-Mail Address		

TYPE OF APPLICATION

- | | | | | |
|--|---|--|--|--------------------------------------|
| <input type="checkbox"/> Initial | <input type="checkbox"/> Renewal | <input type="checkbox"/> Change of Ownership | <input type="checkbox"/> Bed Capacity Change | <input type="checkbox"/> Name Change |
| <input type="checkbox"/> Location Change | <input type="checkbox"/> Change in Services | <input type="checkbox"/> Change in Facility Type | <input type="checkbox"/> Other Change: | |

Check Category:

- ☐
- General Acute Hospital
- ☐
- Primary Care Hospital
- ☐
- Specialized Hospital

North Dakota Administrative Code Section 33-01-01.1-06 requires hospitals submit all accreditation survey results, recommendations, plans of correction, and revisit documentation to our Department if you were surveyed by JCAHO during the past calendar year.

In addition, Section 33-07-01.1-35 of the North Dakota Administrative Code requires specialized rehabilitation services of a hospital submit all Commission on Accreditation of Rehabilitation Facilities (CARF) survey results, recommendations, and plans of corrections to the Department.

Provide copies of all written correspondence relative to your JCAHO and /or CARF survey findings or plan of corrective action during the past calendar year.

Submit a current floor plan (8 ½ x 11) showing the location of all licensed beds and services.

Total Number of Beds (Excluding Nursing Bassinets and Addiction Beds):

Is the Hospital Accredited?

- ☐
- No
- ☐
- Yes – Accrediting Body:
- ☐
- JCAHO
- ☐
- CARF
-
- ☐
- Other

Does the hospital participate in the Federal swing bed program?

- ☐
- No
- ☐
- Yes

Name of Hospital's General Liability Insurance Company

Name of Agent

Address of Agent

City

State

Zip Code

MANAGEMENT AND PERSONNEL

TYPE OF CONTROL (Check One)

GOVERNMENTAL ☐ State ☐ County ☐ County & City ☐ MunicipalNONPROFIT ☐ Association ☐ CorporationPROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation

Name of Exact Ownership of Premises

Mailing Address

City

State

Zip Code

Name of Legal Entity Responsible for Operation (as registered with the ND Secretary of State)

Mailing Address

City

State

Zip Code

Has ownership of this hospital changed in the last twelve months? ☐ No ☐ Yes

Has the legal entity responsible for operation of this hospital changed in the last twelve months?

- ☐
- No
- ☐
- Yes

Is the hospital operating under a management agreement?

- ☐
- No
- ☐
- Yes

	REQUIRED SERVICES:
<input type="checkbox"/>	Medical Staff
<input type="checkbox"/>	Nursing Services
<input type="checkbox"/>	Dietary Services
<input type="checkbox"/>	Medical Record Services
<input type="checkbox"/>	Pharmaceutical Services
<input type="checkbox"/>	Laboratory Services
<input type="checkbox"/>	Radiology Services
<input type="checkbox"/>	Emergency Services (inpatient)
<input type="checkbox"/>	Social Services
<input type="checkbox"/>	Basic Rehabilitation Services
<input type="checkbox"/>	Housekeeping & related services including laundry
<input type="checkbox"/>	Central Services
	COMPLEMENTARY SERVICES:
<input type="checkbox"/>	Nuclear Medical Services
<input type="checkbox"/>	Surgical Services
<input type="checkbox"/>	Recovery Services
<input type="checkbox"/>	Anesthesia Services
<input type="checkbox"/>	Respiratory Care Services
<input type="checkbox"/>	Obstetrical Services
<input type="checkbox"/>	Cardiac Rehab
<input type="checkbox"/>	Chemical Dependency Treatment
<input type="checkbox"/>	Coronary Care Unit
<input type="checkbox"/>	Detoxification
<input type="checkbox"/>	Dialysis:# Stations
<input type="checkbox"/>	Education, Patient/Community Health
<input type="checkbox"/>	Emergency Services (Outpatient/ Public)
<input type="checkbox"/>	Gynecology Services

<input type="checkbox"/>	Home Health
<input type="checkbox"/>	Hospice Care (inpatient)
<input type="checkbox"/>	Mammography
<input type="checkbox"/>	Medical Unit
<input type="checkbox"/>	Neonatal Level I (not normal newborn)
<input type="checkbox"/>	Neonatal Level II (not normal newborn)
<input type="checkbox"/>	Nursery: # Bassinets
<input type="checkbox"/>	Occupational Therapy
<input type="checkbox"/>	Oncology Services
<input type="checkbox"/>	Orthopedics
<input type="checkbox"/>	Outpatient Department
<input type="checkbox"/>	Pediatric Department
<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	Psychiatric Services
<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	Respite Care
<input type="checkbox"/>	Specialized Rehabilitation Services
<input type="checkbox"/>	Speech Pathology
<input type="checkbox"/>	Transplant Services (List):
<input type="checkbox"/>	Other: (List)
<input type="checkbox"/>	Isolation
	INTENSIVE CARE UNITS:
<input type="checkbox"/>	Burn
<input type="checkbox"/>	Cardiac
<input type="checkbox"/>	Neonatal Level III (not normal newborn)
<input type="checkbox"/>	Respiratory Pulmonary
<input type="checkbox"/>	Medical / Surgical

Inpatient Census for 12 Months Acute: High _____ Low _____ Average _____	Swing Bed: High _____ Low _____ Average _____
SIGNATURES AND AFFIDAVIT	
<p>NOTE: The person signing the application cannot be less than 18 years of age. The administrator of the hospital shall not sign the application unless he/she is also a board member. The application must me signed by official (s) of the entity responsible for the operation of the hospital. (If sole proprietorship, the owner shall sign the application; if a corporation, two of its officers shall sign; if a state, county, or municipal unit, the application is to be signed by the head of the department having jurisdiction over the hospital.)</p> <p>The undersigned hereby makes application for a license to operate a hospital subject to the provisions of North Dakota Century Code Chapter 23-16 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. We declare that we have examined this application and all attachments and that to the best of our knowledge and belief, this information is true, correct, and complete. We will notify the Department of Health in writing of any changes in this information within thirty (30) days of any such change.</p>	
_____ Signature	_____ Date
_____ Signature	_____ Date
State of _____)) SS. County of _____)	
On this _____ day of _____, 20_____, before me personally appeared_____	
_____who having been sworn states that to the best of his/her knowledge and beliefs the statements in the foregoing application are true.	
(Seal)	_____ Notary Public
My commission expires _____	

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